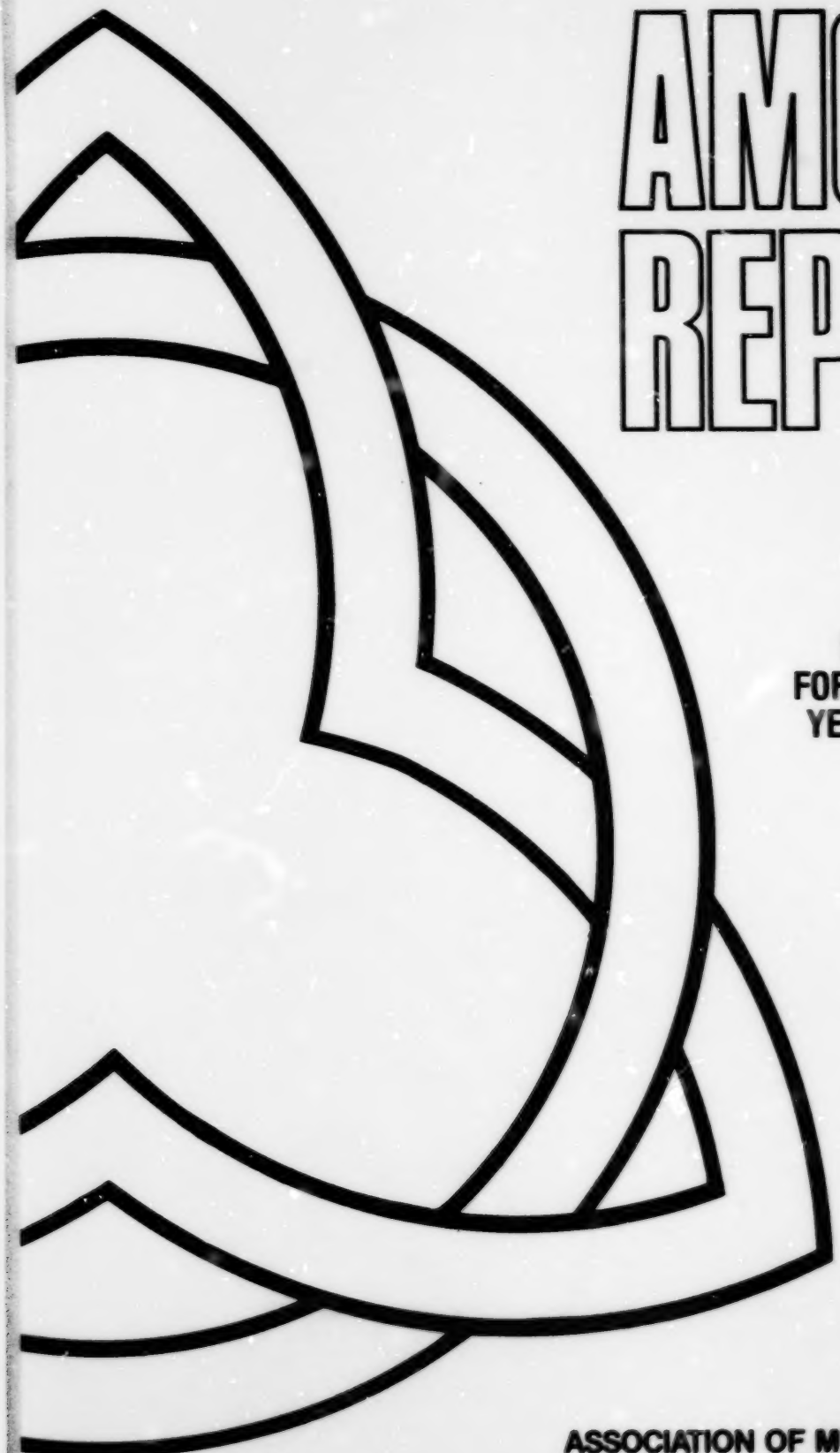

AMO REPORTS 83-9

RESPONSE TO BLUEPRINT FOR CHANGE: THE NEXT TEN YEARS, INTERIM REPORT OF DR. G.F. HESELTINE

ASSOCIATION OF MUNICIPALITIES OF ONTARIO
MAY 1983

84- 4661

ASSOCIATION OF MUNICIPALITIES OF ONTARIO

The Association of Municipalities of Ontario, a non-partisan voluntary organization, is united to promote the values of the municipal government system and the status of the municipal level of government as a vital and essential component of the total intergovernmental framework of Ontario and Canada.

The Association acts as the collective voice of Ontario's municipal governments and is organized to accomplish through cooperation and coordination, what the majority have neither the time nor the resources to do individually.

The Association represents some six hundred (600) municipal governments throughout Ontario. The governing body is composed of some eighty (80) municipal elected and appointed officials, who in turn represent a wide-range of municipal government interest.

The following sections and affiliated municipal professional associations form an important part of the Association's structure and therefore, play an important part in its activities in terms of the Board of Directors, program and policy development:

Association Sections:

* County and Regional Section
* Large Urban Section
* Northern Ontario Section (FONOM/NOMA)
* Rural (ROMA) Section
* Organization of Small Urban Municipalities Section

Association Affiliates:

* Association of Municipal Clerks and Treasurers of Ontario
* Association of Municipal Tax Collectors of Ontario
* Municipal Engineers Association
* Ontario Municipal Administrators Association
* Ontario Municipal Personnel Association
* Ontario Municipal Social Services Association
* Society of Directors of Municipal Recreation of Ontario

To the Municipal Clerk:

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"AMO Reports 83-9" was submitted to the Honourable Claude Bennett, Minister of Municipal Affairs and Housing and the Honourable Larry Grossman, Minister of Health on June 3, 1983.

AMO RESPONSE TO
BLUEPRINT FOR CHANGE: THE NEXT TEN YEARS - INTERIM REPORT OF DR. G.F. HESELTINE

1. INTRODUCTION

The Association of Municipalities of Ontario appreciates this opportunity to respond to Dr. Heseltine's interim report on mental health in the Province of Ontario. The Association is particularly interested in the Provincial Government's policy of deinstitutionalization as this policy has a significant impact on municipalities with respect to providing community based services, including accommodation, income maintenance and other support services. Municipalities have also been urged to accept increasing responsibility for patients who have been returned to the community and who require some form of residential care. This social service aspect is of crucial importance in deinstitutionalization and AMO is concerned that Dr. Heseltine's interim report has placed too much emphasis on the medical aspect of care.

The Association has already noted its concerns and developed recommendations regarding the policy of deinstitutionalization in two previous reports. AMO Reports #62, entitled Housing for the Psychiatrically Impaired, November 1981, focussed its attention on the psychiatrically disabled population and the importance for priority consideration to be given, particularly to their shelter needs. AMO Reports #82-1, entitled Adult Residential Facilities, March 1982, focussed on the impact of deinstitutionalization on municipalities particularly with respect to residential services for adults.

AMO notes that Dr. Heseltine's interim report is intended to be a discussion paper and that the subsequent final report, to be available in the late spring or early summer, will take into account the comments, recommendations and omissions of this interim report. AMO looks forward to receiving and reviewing the final report when it becomes available.

2. JURISDICTION

Proposal

In his interim report on mental health, Dr. Heseltine proposes that the Ministry of Health be recognized as lead Ministry. The Ministry of Health would be responsible for establishing a

province-wide mental health plan and for encouraging co-operation and co-ordination among all Ministries involved in services to the mentally ill.

Comment

AMO agrees that there must be increased co-ordination among the several Ministries involved with the various aspects of mental health, notably Health, Community and Social Services, and Municipal Affairs and Housing. For example, the Ministries of Health and Community and Social Services should co-ordinate their plans with respect to the deinstitutionalization of the various patient groups for whom each Ministry is responsible. There is a limit to the number of persons being deinstitutionalized that communities are able to absorb in any one time period. In addition, there needs to be a way to ensure that not only will patients' medical needs be met, but patients' non-medical needs for housing, income maintenance, and other support services will be met as well.

AMO does not support the proposal for Health to be the lead Ministry. As evidenced by Dr. Heseltine's interim report, AMO believes that the Ministry of Health would focus too much on the medical aspect of care and not enough on the non-medical aspects.

AMO recommends:

1. a) That the Secretariat for Social Development convene a meeting to include representatives from the Ministries of Municipal Affairs and Housing, Health, Community and Social Services and representatives from the Association of Municipalities of Ontario to develop and implement a strategy whereby co-operation and co-ordination among all the Ministries involved in the services to the mentally ill will be achieved, and to establish a lead Ministry.

   b) That the Secretariat for Social Development be given sufficient power, authority and resources to carry out this mandate.

2. That regardless of who is given the authority and responsibility for services to the mentally ill, this body must take the initiative to guarantee that patients' medical needs and non-medical needs for housing, income maintenance and other support services will be met.

3. DEINSTITUTIONALIZATION

A) Basic Assumptions

Proposal

Dr. Heseltine makes four basic assumptions regarding the discharge of psychiatric patients to the community. In summary, they include the following:[1]

1. Not all psychiatric patients currently residing in various institutions could or should be discharged. There will remain a continuing role for the psychiatric institution as one of the dispensers of care in the Community. There will always be some patients who will need, at some point, the security of the psychiatric hospital for their own or the community's safety.

2. Placement in the community should not automatically be assumed to be better than placement in an institution. No psychiatric patients should be discharged until appropriate accommodation, facilities and programing exist in the community and are likely to continue to exist.

3. The easiest way to prevent institutionalization is to forestall the patient's admission in the first place. Any system developed must therefore have the capacity to handle not only existing patients but to anticipate and plan for the "market" and cope accordingly.

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[1] Heseltine, Dr. G.F., Blueprint for Change: The Next Ten Years (Interim Report), 1982, Page VII.1

4. Any new system, at least in the early stages, must be run in parallel with the existing system and therefore will result in a net increase in the expenditure of dollars.

Comment

AMO agrees with Dr. Heseltine's assumptions and would like to stress that appropriate community based services including accommodation, income maintenance and other support services must exist in the community and be likely to continue to exist before patients are released into the community. Preparatory programs should also be available to patients within the institution prior to their release. In addition, any new system developed must have the capacity to accommodate new patients who will no longer be institutionalized. Finally, it will be necessary for the Province of Ontario to allocate sufficient funding for programs and services to the mentally ill both within the institution and in the community, in order to prevent deinstitutionalization from becoming an abdication of the Provincial Government's responsibility and an intolerable burden on local communities.

AMO recommends the following:

3. That persons requiring institutional attention for mental handicaps continue to have access to psychiatric institutions. Psychiatric institutions should continue to exist as one of the dispensers of care in the community. Not all psychiatric patients currently residing in various institutions should be discharged, and there will always be some patients who will need, at some point, the security of a psychiatric hospital for their own or the community's safety.

4. That appropriate community based services including accommodation, income maintenance and other support services exist in the community and be likely to continue to exist prior to the discharge of psychiatric patients from institutions.

5. That patients about to be released into the community receive appropriate advance preparation and have access to preparatory programs within the institution prior to their release.

6. That appropriate community based services be made available in the community to accommodate not only deinstitutionalized psychiatric patients, but non-institutionalized psychiatric patients as well.

7. That the Province of Ontario allocate sufficient funding for programs and services to the mentally ill such as preparatory programs within institutions and appropriate accommodation and support services within the community, so that the Provincial Government will be able to meet its responsibility to deinstitutionalized and non-institutionalized psychiatric patients.

B) Planning

Proposal

Dr. Heseltine indicates the importance of establishing a province-wide mental health plan and acknowledges that until now there has really been very little planning. He states that "mental health planning in the province has involved piecemeal trouble shooting aimed at individual components of the system and tending simply to address symptoms rather than basic concerns. A major problem has been that individual practitioners, professional groups, or community representatives have been able to promote successfully their particular interest... . As a result the needs of the mental health system as a whole have been sacrificed and particular components or locations have received disproportionate resources".[2]

One of the features to be included in a province-wide plan would be "the availability of a wide range of services in each region from 24-hour intensive in-patient care to post-discharge follow-up and community support such as accommodation, vocational and life skills training, income maintenance and advocacy that will allow the matching of level of care to patient needs".[3]

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2 Ibid, page III.11

3 Ibid, page V.2

Comment

Planning is obviously essential in order to develop the comprehensive mental health care delivery system as is being proposed. The report states that planning is a process which requires accurate, up-to-date information. "If this is lacking, there is no quantitative basis for knowledgeable and specific problem definition and hence no basis upon which to develop a plan".[4] The report states that "In Ontario, at the present time, there is no province-wide systematic data collection or available information that meets the requirements of either service delivery planning or evaluation".[5] In addition, the report acknowledges that the available community accommodation for discharged patients is unknown.

If the Ministry of Health plans to continue to carry out its policy of deinstitutionalization, data collection must become a priority in order to develop the necessary plans. In addition, because the development of a community based service system will have a significant impact on municipalities, AMO believes it is essential for municipalities to be involved in the planning process, particularly with respect to discussions on accommodation, income maintenance and other community support services. AMO notes that an inter-Ministry Committee has been established to examine issues of accommodation, and community support and believes it would be appropriate for representatives of the Association to be invited to participate.

AMO therefore recommends:

8. That the Ministry of Health allocate sufficient funding for research for mental health services for data collection and program evaluation.

9. That the Secretariat for Social Development initiate a consultation process whereby representatives from the Ministries of Health, Community and Social Services, and Municipal Affairs and Housing, local health care and social service agencies, and the Association of

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4 Ibid, page III.11

5 Ibid, page III.11

Municipalities of Ontario will be able to provide input in the development of a province-wide mental health plan and to ensure co-ordination among all the services in the community.

10. That the Association of Municipalities of Ontario be invited to participate on the inter-Ministry Committee which has been established to examine the issues of accommodation and community support. As a priority, the terms "community" and "community support" should be defined.

C) The Change in Hospital Care

Proposal

Dr. Heseltine proposes that ideally, the locus of mental health care delivery should be consistent with the levels of care required. Three levels of care are considered: Intramural, Extramural and Community Care.[6]

Intramural care is the most specialized and intensive level, and involves "active" in-patient care for patients who need 24-hour intensive assessment and treatment by psychiatric, nursing, medical, and other mental health professional staff.

Extramural levels include direct services from mental health professionals for patients living in community settings, and for long-term patients who need major assistance in activities of daily living. It would include psychiatric out-patient care and partial hospitalization, and rehabilitative psychiatric environments which have skilled nursing facilities such as group homes, special care homes, or room and board situations which are operated, staffed or managed by a psychiatric facility.

The community level involves a wide range of generic and support services for patients with limited mental health care needs, who can be appropriately cared for by family physicians or other community resources. Generic services include visiting nurse programs, private physicians, homemaker services and sheltered workshops. Other community resources would include

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6 Ibid, page II.3

nursing homes, group homes, special care homes, and foster homes. Hospital psychiatric staff should provide consultation and backup staff in these services.

The concept of the "pivotal" general hospital is essential to the above mentioned model. Dr. Heseltine suggests that the "pivotal" general hospital in the community is the "pivot" in the system and would provide the balance between the services provided in the community, the psychiatric units or general hospitals, special hospitals and the psychiatric hospitals. The "pivotal" hospital would also serve as community co-ordinator of agencies, be involved in crisis intervention, back-up for patients existing in the community, and support for agencies in that community. They would be specially designated to have a central relationship to all other mental health services to patients and to their communities and encourage the development of community support services.

Comment

With respect to the proposals as set out in the report, the first point to be noted is that access to the appropriate level of care must be assured to all residents of Ontario, regardless of their needs, their place of residence, their socioeconomic or cultural status or the language they speak. For those patients receiving care outside the hospital wards (extramural and community level patients), it will be necessary to ensure that these patients are not lost or neglected, but do in fact receive the necessary community based services including accommodation, income maintenance and other support services. It should be noted that the difference between the services being proposed for the extramural and community level patients is not clear, particularly as group homes and special care homes are specified for both.

AMO questions the feasibility of Dr. Heseltine's proposal as the Association is unsure whether hospitals have the capacity to fulfill the role of "pivot" in the system. The Association also questions the fundamental assumption that a hospital can successfully co-ordinate service delivery of a community mental health program. AMO believes that the system to provide community based services should be developed and delivered in the community if it is to be effective.

D) Community Based Services

Proposal

The community based service system includes appropriate accommmodation, income maintenance, and other support services. Dr. Heseltine acknowledges that the post-institutional environment is of critical importance for the discharged psychiatric patient, and the availability of community support services is crucial for those who require periodic assistance. In addition, Dr. Heseltine points out that community services and after-care for psychiatric patients must be viewed as tertiary prevention and given high priority.[7] It is further proposed that there be a case manager to co-ordinate all the community based services.

Comment

The proposed community based service system will affect municipalities in that they will be forced to provide additional accommodation. There will also be increased demand for General Welfare Assistance, Special Assistance, Supplementary Aid and medical and dental services. Some municipalities will need to hire additional staff, and staff will need to have special training to enable them to work with discharged psychiatric patients. Municipalities are being encouraged to lessen the use and presence of restrictive zoning by-laws; however, municipalities will first want to be assured that appropriate services are available for the care of deinstitutionalized psychiatric patients in order to minimize community fears.

AMO wants to stress that municipal budgets will not be able to accommodate increased costs to provide necessary community based services and therefore recommends:

11. That the Province of Ontario commit itself to assuming all costs arising from deinstitutionalization and the development of the community based service system, and to ensuring that no additional burden is added to the local tax base.

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7 Ibid, page IX.11

1. The Case Manager Concept

Proposal

This proposal involves giving one specific person the responsibility for a patient in order to provide continuity of care in the community. Five major roles could be performed by the case manager.

a) Treatment co-ordination - the case manager would not be responsible for providing direct treatment to the patient, but would provide continuity for the patient during all phases of treatment.

b) Advocacy for services on behalf of the patients - the case manager could act as the patient's agent in dealing with the bureaucracy, for example in obtaining social assistance, in dealing with eviction notices, income tax forms, etc.

c) Resource management and purchase - the case manager would assist the patient in obtaining access to the non-clinical community support services required to provide autonomy and independent status in the community.

d) Employment and activity support - the case manager's role would be to assist the patient in obtaining appropriate employment and/or activity.

e) Accommodation support - the case manager's role would be to ensure that appropriate accommodation for the patient is found in the community.

The report further proposes that public health nurses be recognized as the case managers because public health nurses already work with a large caseload of chronically disturbed psychiatric patients in the community in both urban and rural areas[8].

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8 Ibid, page VIII.18

Comment

AMO agrees that continuity of care is essential for the discharged patient and that this can be best achieved by giving the patient access to one person, and making one person responsible for a patient in the community. AMO therefore supports the case manager concept. In order for the case manager to be of any use, however, the community based services such as appropriate accommodation, and other support services must be available. In addition, as noted by Dr. Heseltine, case managers must have sufficient authority to back up requests made on behalf of a patient. Case managers must also have sufficient time to devote to their duties.

AMO questions whether the case manager role should be restricted to public health nurses. Public health nurses have no expertise in income maintenance or landlord/tenant matters and to designate these nurses to carry out such roles is to shift the focus of their duties away from health. The case manager has a generalist role and although in some communities it may be appropriate for public health nurses to serve as case managers, AMO does not believe public health nurses are necessarily the most appropriate persons to carry out the proposed mandate.

AMO therefore recommends:

12. That there be a case manager assigned to each deinstitutionalized psychiatric patient in order to assist each patient in the community and to provide some continuity of care. The case manager should be funded 100% by the Provincial Government and should be any person whose qualifications would indicate an ability to carry out the duties as mandated by the Provincial Government.

2. Accommodation

Proposal

The report proposes that treatment should be perceived as a separate function from accommodation and that patients should not be maintained in hospital for residential care simply because

they need somewhere to live[9]. Intramural care should no longer be used for patients whose treatment needs can be met at the extramural or community level.[10]

Comment

Accommodation is of crucial importance in deinstitutionalization. However, although Dr. Heseltine recognizes that the availability of and access to appropriate post-discharge accommodation is a particularly crucial issue, the report fails to resolve the question of who will ultimately be responsible for providing the appropriate accommodation, who in fact will provide it, and who will fund it. In fact, this issue appears to be a perfect example of a key component in deinstitutionalization which has fallen through the cracks of interministerial jurisdiction.

The Ministry of Health appears to be reluctant to take responsibility when the report states "If accommodation is an integral part of treatment, then it is the Ministry of Health's responsibility to fund accommodation. However, if the patient's treatment needs do not include 24-hour care, provision of shelter is not the direct responsibility of the Ministry of Health"[11]. In addition, Dr Heseltine states "The Ministry's primary responsibility is the provision of treatment, not shelter. However, it is important that the Ministry, while not assuming primary responsibility for accommodation, encourage the other appropriate Ministries to do so."[12]

Dr. Heseltine's comment that "the Ministry's primary responsibility is the provision of treatment, not shelter", is unacceptable to AMO. It is obvious that treatment cannot be provided to a patient who has no shelter. There is currently a shortage of affordable and appropriate housing, and unless the "lead

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9 Ibid, page IV.2

10 Ibid, page VIII.14

11 Ibid, page VIII.1

12 Ibid, page IV.2

Ministry" assumes responsibility to ensure that the Provincial Government funds and commits itself to providing appropriate accommodation with a wide range of residential services, it is unlikely that the Provincial Government will be able to meet its responsibility to deinstitutionalized psychiatric patients. The Provincial Government must provide the necessary accommodation in order for AMO's endorsation of deinstitutionalization to be forthcoming.

AMO therefore recommends:

13. That the Province of Ontario ensure that appropriate accommodation, with a wide range of residential services be provided for deinstitutionalized and non-institutionalized psychiatric patients.

3. Income Maintenance

Proposal

The report states that the Ministry of Health has initiated discussion with the Ministry of Community and Social Services to address the issue of providing adequate income support to the psychiatrically impaired. In addition, Dr. Heseltine acknowledges that access to sufficient money to maintain a standard of living consistent with good nutrition and an appropriate place to live is essential for mental as well as physical health.[13]

Comment

There are two issues to be addressed with respect to income maintenance. One is the level of assistance, and the other is the eligibility criteria for Family Benefits. Many of the psychiatrically impaired receive General Welfare Assistance. They are often not accepted by the Province for Family Benefits as they are not considered permanently unemployable according to the Provincial criteria. This issue has been one of long-standing concern to municipalities, and AMO would like to be involved in discussions regarding income maintenance.

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13 Ibid, page IX.12

AMO therefore recommends:

14. That in recognizing the Provincial financial responsibility to long-term recipients of social assistance, AMO be invited to participate in discussions with the Ministries of Health and Community and Social Services regarding the provision of social assistance to the psychiatrically impaired and regarding the development of new criteria whereby long-term psychiatrically impaired patients will be eligible for Family Benefits.

4. Support Services

Proposal

Dr. Heseltine recognizes that in addition to accommodation and income maintenance, certain other support services must exist in the community to maintain and rehabilitate the psychiatrically disabled.

Comment

AMO believes that the additional support services should include social, recreational and educational activities, life skills training, and vocational opportunities to assist the psychiatrically disabled to enter or re-enter the workforce. These programs should be included in a service plan and the details of implementation should be left up to municipalities.

AMO therefore recommends:

15. That in addition to appropriate accommodation and income maintenance, the community based service system should include local support services such as social, recreational and educational activities, life skills training, and vocational opportunities, to maintain and rehabilitate the psychiatrically disabled. These programs should be included in a jointly agreed to service plan and the method of implementation should be agreed to by municipalities.

4. SUMMARY OF RECOMMENDATIONS

1. a) That the Secretariat for Social Development convene a meeting to include representatives from the Ministries of Municipal Affairs and Housing, Health, Community and Social Services and representatives from the Association of Municipalities of Ontario to develop and implement a strategy whereby co-operation and co-ordination among all the Ministries involved in the services to the mentally ill will be achieved, and to establish a lead Ministry.

   b) That the Secretariat for Social Development be given sufficient power, authority and resources to carry out this mandate.

2. That regardless of who is given the authority and responsibility for services to the mentally ill, this body must take the initiative to guarantee that patients' medical needs and non-medical needs for housing, income maintenance and other support services will be met.

3. That persons requiring institutional attention for mental handicaps continue to have access to psychiatric institutions. Psychiatric institutions should continue to exist as one of the dispensers of care in the community. Not all psychiatric patients currently residing in various institutions should be discharged, and there will always be some patients who will need, at some point, the security of a psychiatric hospital for their own or the community's safety.

4. That appropriate community based services including accommodation, income maintenance and other support services exist in the community and be likely to continue to exist prior to the discharge of psychiatric patients from institutions.

5. That patients about to be released into the community receive appropriate advance preparation and have access to preparatory programs within the institution prior to their release.

6. That appropriate community based services be made available in the community to accommodate not only deinstitutionalized psychiatric patients, but non-institutionalized psychiatric patients as well.

7. That the Province of Ontario allocate sufficient funding for programs and services to the mentally ill such as preparatory programs within institutions and appropriate accommodation and support services within the community, so that the Provincial Government will be able to meet its responsibility to deinstitutionalized and non-institutionalized psychiatric patients.

8. That the Ministry of Health allocate sufficient funding for research for mental health services for data collection and program evaluation.

9. That the Secretariat for Social Development initiate a consultation process whereby representatives from the Ministries of Health, Community and Social Services, and Municipal Affairs and Housing, local health care and social service agencies, and the Association of Municipalities of Ontario will be able to provide input in the development of a province-wide mental health plan and to ensure co-ordination among all the services in the community.

10. That the Association of Municipalities of Ontario be invited to participate on the inter-Ministry Committee which has been established to examine the issues of accommodation and community support. As a priority, the terms "community" and "community support" should be defined.

11. That the Province of Ontario commit itself to assuming all costs arising from deinstitutionalization and the development of the community based service system, and to ensuring that no additional burden is added to the local tax base.

12. That there be a case manager assigned to each deinstitutionalized psychiatric patient in order to assist each patient in the community and to provide some continuity of care. The case manager should be

funded 100% by the Provincial Government and should be any person whose qualifications would indicate an ability to carry out the duties as mandated by the Provincial Government.

13. That the Province of Ontario ensure that appropriate accommodation, with a wide range of residential services be provided for deinstitutionalized and non-institutionalized psychiatric patients.

14. That in recognizing the Provincial financial responsibility to long-term recipients of social assistance, AMO be invited to participate in discussions with the Ministries of Health and Community and Social Services regarding the provision of social assistance to the psychiatrically impaired and regarding the development of new criteria whereby long-term psychiatrically impaired patients will be eligible for Family Benefits.

15. That in addition to appropriate accommodation and income maintenance, the community based service system should include local support services such as social, recreational and educational activities, life skills training, and vocational opportunities, to maintain and rehabilitate the psychiatrically disabled. These programs should be included in a jointly agreed to service plan and the method of implementation should be agreed to by municipalities.

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82-22 Bill 179 - An Act Respecting the Restraint of Compensation in the Public Sector of Ontario and the Monitoring of Inflationary Conditions in the Economy of the Province

83-1 Response of the Association of Municipalities of Ontario to the 1983 Provincial Transfer Payment Announcement

83-2 Affordable Housing - An Overview

83-3 Response to the Ministry of Energy Discussion Paper: Wood Heat Inspection Safety Program for Ontario

83-4 Response to the Discussion Paper on Ontario Carbonated Soft Drink Container Regulations

83-5 Reform and Revision of Conservation Authorities in Ontario

83-6 Response to The Children's Act

83-7 Response to the Provincial Government Discussion Paper Entitled Municipal Cost-Sharing and Unconditional Grants

83-8 Response to the Ontario Public Library System Consultation Paper: A Foundation for the Future

83-9 Response to Blueprint for Change: The Next Ten Years, Interim Report of Dr. G.F. Heseltine

83-10 Response to the Study of Residential Intensification and Rental Housing Conversion, Part 1: Detailed Summary of Findings and Recommendations

83-11 Response to a Ministry of the Environment Discussion Paper: Guidelines for the Regulation and Siting of Mobile PCB Destruction Facilities

83-12 Response to the Ministry of Revenue's Proposals on Property Tax Exemptions for Non-Profit Community-Based Organizations

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